Section 125 Reimbursement Claim Form

FAILURE TO FULLY COMPLETE THIS FORM MAY DELAY REIMBURSEMENT

Employer Name: _____

Employee Name: _____ Last 4 SSN: _____

Mailing Address: _____

Phone: _____ E-Mail: _____

HEALTHCARE FSA

PLEASE INCLUDE A COPY OF YOUR EOB, BILL, STATEMENT, OR RECEIPT. CREDIT CARD SLIPS, CANCELLED CHECKS, AND BALANCE FORWARD STATEMENTS ARE UNACCEPTABLE FORMS OF SUBSTANTIATION.

PERSON COVERED	SERVICE PROVIDER	DATE(S) OF SERVICE	AMOUNT
		TOTAL	

DEPENDENT CARE FSA

IF NO RECEIPT IS AVAILABLE, PLEASE HAVE PROVIDER SIGN THE BOTTOM OF THIS SECTION.

PERSON COVERED	SERVICE PROVIDER	DATE(S) OF SERVICE	AMOUNT
PROVIDER TAX ID OR SSN:		TOTAL	
PROVIDER SIGNATURE:			

I CERTIFY THE ABOVE EXPENSES QUALIFY FOR REIMBURSEMENT UNDER THE TERMS OF THE PLAN. I SPECIFICALLY STATE THAT THE EXPENSES LISTED HAVE BEEN INCURRED FOR MY OR MY ELIGIBLE DEPENDENTS' BENEFIT. I HAVE INCLUDED ACCEPTABLE PROOF OF EXPENSE WITH THIS FORM. I CERTIFY THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE AND THAT ALL OUT-OF-POCKET EXPENSES REIMBURSED TO ME UNDER THIS PROGRAM WILL NOT BE DEDUCTED ON A TAX RETURN OR REIMBURSED BY ANY OTHER MEANS.

Employee Signature: _____ Date: _____

Mail: 6939 Sunrise Blvd., Ste. 250, Citrus Heights, CA 95610
Phone: (866) 446-1072 Fax: (916) 221-5040 E-Mail: transactions@tdsplans.org